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to: Participants, National High Blood Pressure Education Program

from: Graham W. Ward, Program Coordinator

1982, No. 2

Editorial

HBP under block grants: New players, new priorities

The recent adoption of the block grant system for allocating Federal funds to the states changes some of the procedures hypertension control programs have been used to following and some of the people and agencies we've been dealing with. As we adjust to the new system, some of our priorities and strategies will need to change as well.

Regarding new procedures and agencies involved under the block grants, the Federal responsibiliy for overseeing hypertension monies has shifted from the Bureau of Community Health Services (BCHS) which administered the 317(a)(1) project grants, to the Centers for Disease Control (CDC), which is administering the entire Preventive Health Services block grant. The InfoMemo will outline in detail the scope of CDC responsibilities in an upcoming issue.

One broad way in which CDC's role will differ from that of BCHS, however, is that CDC will not be monitoring or evaluating the nature or outcome of state HBP efforts. Unlike 317(a)(1) grants, the block grants require no state accountability. For example, 317(a)(1) grants specifically mandated that states target HBP services to high risk, hard-to-reach populations. We encourage states to continue this focus, even though it is no longer a funding requirement.

At the state level, the state health departments will continue to administer Federal hypertension funds. Whereas, the size of 317(a)(1) grants to each state was decided by BCHS under block grants the state legislature will approve, reject, or modify the funding request that the governor and his or her administrative agencies prepare.

Cont. on p. 2, Editorial

New guidebook available for patient tracking

Patient tracking, a coordinated set of actions for documenting and monitoring blood pressure levels and related patient behaviors, is a tool for evaluating both the treatment progress of individual hypertensives and the overall effectiveness of HBP control activities. Because almost all HBP programs can benefit from some form of tracking, the NHBPEP has developed a new patient tracking guidebook that outlines basic planning, operating, and evaluation procedures, including more than 20 sample forms and charts. The guide is the result of a Program study that examined 134 patient tracking systems nationwide, and the advice offered is based on a compilation of their experiences.

The information is adaptable to a variety of health care settings and organizations that use patient tracking systems, including:

- State and local health agencies. Many state agencies set guidelines, protocols, and record-

Cont. on p. 2, Guidebook

National High Blood Pressure Education Program National Heart, Lung, and Blood Institute
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Cont. from p. 1, Editorial

Although the Preventive Health Services block grant does require the states to allot a guaranteed percentage of Federal funds to HBP for the next 3 years (see InfoMemo, October 1981), the nature of the political process makes local program visibility increasingly important. The guaranteed funding for HBP is a floor, not a ceiling. States may elect to invest more than the required minimum, and we recommend that they do. Clearly, however, local programs that use the mass media, public forums, and one-to-one conversations with influential leaders to communicate their achievements and their future needs increase the likelihood of larger state allocations. They will also have an advantage in competing for nongovernmental community resources, a competition that will include many worthy, credible health and social programs. An important opportunity to make local HBP needs and accomplishments known to state and community decisionmakers is coming up. Beginning in fiscal 1983, states will be required to hold public hearings regarding their plans for allocating block grant funds.

The current efforts to reduce Federal spending and increase state responsibility for public programs mean that finding and developing local resources will be another important local program priority. One such resource is the worksetting, including the largely untapped potential of the worksite as a source of HBP care for employee dependents. Because a large proportion of an employer's health care costs relates to dependent expenses, cost-conscious companies with a strong employee HBP program may be interested in this expansion. Companies just starting a HBP effort should probably develop a workable employee program first, to get experience in running such an effort and to document results on which to base future plans.

The InfoMemo will report on this and other local program strategies for developing local resources in upcoming issues.

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Cont. from p. 1, Guidebook

keeping forms for local health departments to use in patient tracking. They may also maintain computerized patient medical information. Local health agencies supply the state with data and may develop long-term tracking systems in conjunction with HBP services they provide.

- Communitywide programs. Some local HBP programs centralize patient tracking for many health care settings within the community. These programs may provide long-term tracking services for several local programs or they may coordinate systems that operate independently.
- Voluntary health organizations. Groups like American Heart Association affiliates who sponsor detection and referral activities often use patient tracking to determine whether referral appointments are made and kept.
- Hospitals. Many hospitals operate patient registries, and they may use tracking techniques to enhance treatment adherence in their hypertension outpatient clinics.
- Private medical practices. Physicians provide the most basic tracking information by keeping HBP treatment flow sheets and patient medical records. They use these forms to monitor progress toward control and they may share this information with community tracking programs.
- Pharmacies. Some pharmacies measure BP's regularly and monitor patient progress toward goal blood pressure. Others track whether or not patients refill prescriptions on time.
- Workplace. Like local health agencies, worksite programs may offer tracking services that complement the education, referral, and treatment activities they sponsor. The occupational health

department or union may be involved in patient tracking; smaller companies usually cooperate with another community organization for tracking activities.

The Planning Process

The tracking guidebook gives programs that want to develop patient tracking activities some practical guidelines for planning them. The planning process begins with setting goals, because they provide both a foundation and a focus for the tracking system. The guide stresses that the goal is not establishing a tracking system but what a program wants to accomplish with patients. The form and complexity of the tracking system a program chooses will depend in part on its goals.

For example, a program that wanted to increase the number of people successfully referred for care would establish a less extensive tracking system than one that wanted to increase the number of people under control.

The guide also offers practical suggestions for assessing current HBP activities, available resources for tracking (staff, facilities, record- keeping system), and the characteristics and needs of the patient population. These factors are also important considerations in deciding what kind of tracking system to adopt. One result of assessment may be the need or desire to make a cooperative arrangement with another program; the guide outlines how and where to seek this assistance.

Operating a Patient Tracking System

The three elements of patient tracking are patient contact, record-keeping, and alert mechanisms. The guide explains the purpose and nature of each and discusses the advantages and disadvantages of different methods in operating a tracking system.

- Patient contact. In addition to describing successful techniques for telephone contact, mail contact, and home visits, the guide discusses how to develop a standard procedure for staff to follow in making the contacts: what actions to take and when to take them. It also deals with interpersonal skills and patient education, which are important to the success of patient followup.
- Record-keeping. The guide outlines the scope of documentation possible in a tracking system and the uses of and ways to obtain and organize information on: patient background, medical history, BP control status, physician's comments, prescription information, appointment-keeping record, and method/outcome of patient contact, including education and counseling activities. It also suggests ways to ensure the confidentiality of this information, and mechanisms for sharing data with cooperating agencies.
- Alert mechanisms. Alert mechanisms trigger HBP control activities, and serve as a starting point in the tracking process. The guide explains how to use the two most common ones, the appointment book and the "tickler" file.

Evaluation

A patient tracking system collects information that not only measures individual progress but also allows programs to monitor program progress. The guide outlines how to compile individual figures into usable aggregates that relate to program goals and follow consistent standards (for easy comparisons over time). It also explains how to use evaluation results to improve aspects of the HBP control process, pinpoint the causes of problems, and determine the effect of activities.

HBP control programs can use patient tracking systems in a variety of ways to measure progress towards a variety of goals. Regardless of its particular application, however, an important underlying purpose of patient tracking is to keep all those with hypertension control needs in the HBP control system.

The new definition of HBP, currently being drafted by a National High Blood Pressure Coordinating Committee National Advisory Panel, may markedly increase the number of people who are at greater than minimal risk but for whom treatment efficacy has not been shown. Patient tracking will be particularly vital with this group, potentially the largest proportion of hypertensives, yet those who may have the least contact with health care providers and other souces of HBP support.

To obtain a copy of the guide, contact HBPIC, 120/80 National Institutes of Health, Bethesda, MD 20205

McDonald's tests nutrition labeling

The McDonald's Corporation has begun experimental nutrition labeling, including sodium content, in 30 stores in 3 market areas. The fast-food firm is providing standard nutrition labeling information on tray liners, bag stuffers, and posters for eight or nine meal combinations. In addition, McDonald's is promoting a new booklet, Good Food, Good Nutrition and McDonald's to explain the role of fast foods in a balanced diet. The book was written by staff nutritionists consulting with the Tufts Nutrition Institute in Boston.

McDonald's plans a followup survey to determine the impact of the campaign in the Fort Wayne, Indiana, Bakersfield, California, and Madison, Wisconsin, test areas.

HDFP update: Systematic care reduces stroke rate

The Hypertension Detection and Follow-up Program (HDFP), which previously reported that patients receiving systematic care in HDFP clinical centers had a 16.9 percent lower all-cause mortality rate than patients receiving routine care in the community, has now compared cardiovascular disease morbidity and mortality rates in the same groups. Results show that:

- The 5-year stroke incidence rate for the HDFP was 35 percent lower among clinic-treated patients (1.9 per 100) than among those referred to their usual sources of care (2.9 per 100). This improved outcome for the HDFP-treated group occurred for all race-sex and age groups, all strata of diastolic blood pressure, and among those with and without long-standing hypertension.
- The HDFP-treated patients also had a lower 5-year death rate for stroke than the referred care group (1.06 per 1000 vs. 1.91 per 1,000, respectively). In fact, rates for the HDFP-treated group were reduced to a level approaching that of the general U.S. population of (0.83 per 1,000 for age group 35-74, 1974-78).

As reported in InfoMemo No. 19 (Spring 1980), the HDFP was a community-based, randomized, controlled clinical trial with nearly 11,000 participants at 14 sites. Patients at the HDFP centers received a standardized stepped care program of uninterrupted drug therapy. The centers facilitated treatment adherence by providing free care, drugs, and transportation (when necessary) to checkups; by minimizing waiting time using nonphysician health professionals; and by emphasizing a variety of adherence-promotion techniques. Counseling emphasized drug therapy maintenance, but also included attention to other risk factors such as smoking, excess sodium intake, and overweight when participants were interested.

For further information, contact: Scientific Project Officer, HDFP, DHVD, Room 6A-14, Federal Bldg., National Institutes of Health, Bethesda, MD 20205.

Physician assistant aids MD's in HBP control

In additon to other health care functions, a physician assistant, Craig Bruno, helps a physician team in Plymouth, North Carolina, provide HBP control services to hypertensive patients. Under the doctor's supervision, Mr. Bruno routinely:

- takes detailed patient histories;
- peforms physical examinations, including resting and after-exercise BP's;
- prescribes drugs according to a protocol he and the physician determine;
- initiates nondrug therapies;
- provides patient education and counseling;
- carries out management regimens; and
- performs followup activities.

When a patient first enters the clinic, Mr. Bruno takes the patient's history and performs the physical examination. If the BP levels indicate hypertension, he discusses the diagnosis and his suggestions for the patient's therapy with the doctors. Cholesterol levels and additional data help establish a baseline description of CVD risk and indicators for the patient's regimen. Mr. Bruno then talks with the patient about hypertension, the prescribed drug therapy, exercise, and diet changes to control sodium intake and weight. The treatment plan for each patient follows the specific protocol agreed upon among the doctors and the PA.

Bruno's role as patient educator and counselor is especially helpful in encouraging and guiding patients to make diet changes to control HBP. He determines the sources of sodium in the patient's diet and tells the patients specific ways to reduce sodium intake. Plymouth's low-income, rural population consumes a diet high in sodium and pork. Patients are also encouraged to reduce pork intake.

The patient returns in 6 to 7 days for a BP check and additional counseling if diet changes or adherence to drug therapy are problematic. Alterations in drug therapy are discussed among the physicians and Mr. Bruno before dosages or drugs are changed.

A 1968 graduate of the first U.S. physician assistant program at Duke University, Durham, N.C., Mr. Bruno also provides HBP services to the Plymouth community in other ways. He checks blood pressures at the local Weyerhauser plant 1 day a week and conducts classes on stress management and exercise. Local high schools promote exercise for students through his frequent speeches to the student body. He has also spoken at Lion's Club, Girl Scout, and other community meetings. Physician assistants are relatively new members to the health care system in the U.S. Educated in 52 programs throughout the Nation, 1,500 PA's graduate each year. Currently, 8,000 PA's certified by the National Commission on Certification of Physician Assistants, serve in 49 states and the District of Columbia.

For more information on PA's, contact: American Academy of Physician Assistants, 2341 Jefferson Davis Highway, Suite 700, Arlington, VA 22202; (703) 920-5730. Also: Mr. Craig Bruno, Plymouth Clinic, Plymouth, NC; (919)793-4155.

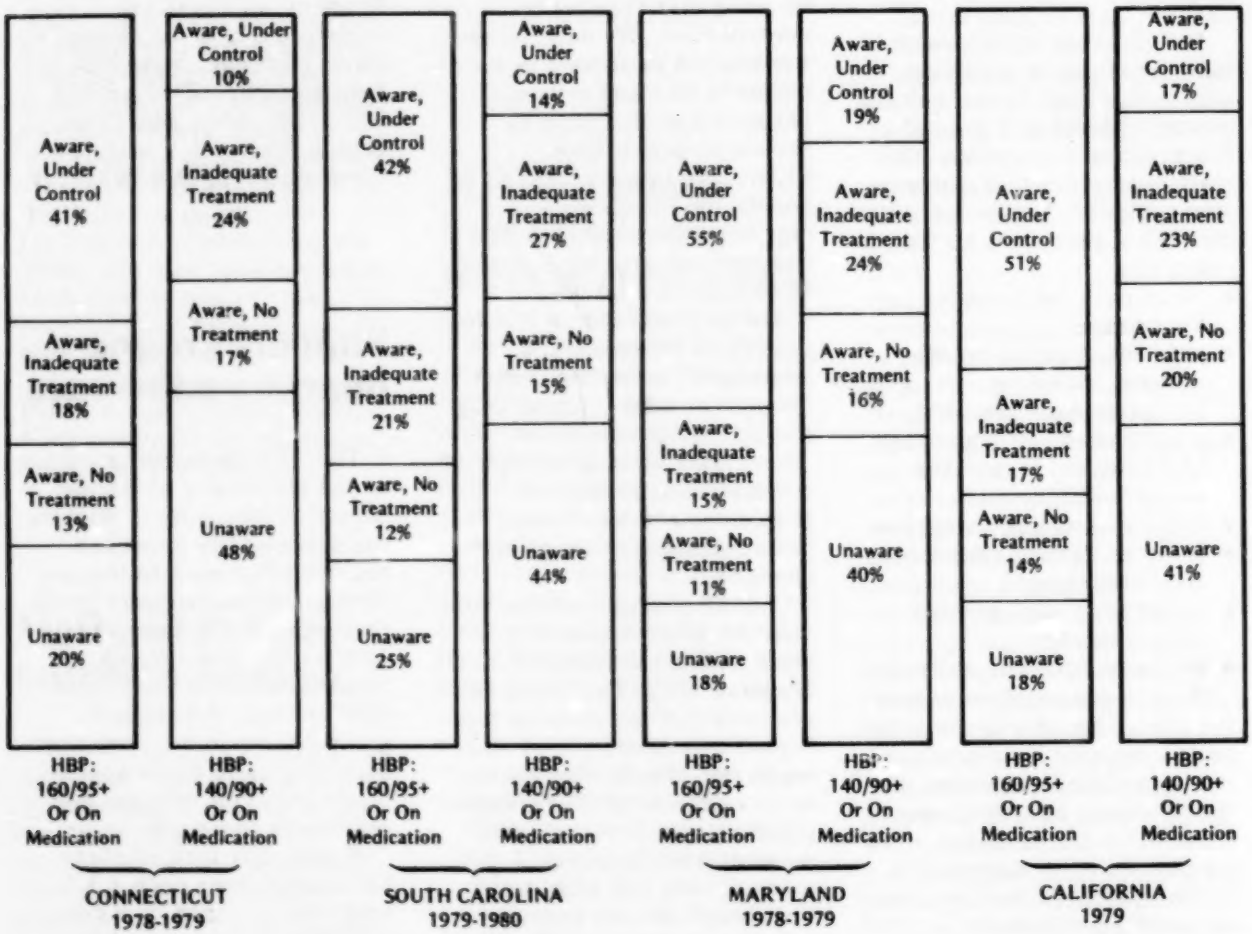
Support groups improve adherence

The "It's Up to Me" program at the University of Kansas School of Medicine in Wichita has successfully improved patient adherence to therapy through mutual support group counseling techniques. While emphasizing the individual's responsibility for long-term HBP control, the support group environment motivates participants to make appropriate behavior changes and reinforces those who do so.

A specially trained nurse facilitator leads each 1 1/2 hour session creating a comfortable atmosphere where participants feel free to discuss their difficulties in maintaining behavior changes. A client-nurse contract allows for individualized care and promotes the concept of self-responsibility for health. Although participants do not receive tangible rewards for successfully completing their contracts, they do receive

Cont. on p. 7, Support

Percent of Hypertensives in Specified Awareness, Treatment, and Control Status Categories, Preliminary Data From Four Statewide Demonstration Projects



State Demonstration Projects Report New Awareness, Treatment, and Control Status Data

Data collected between 1978 and 1980 as part of four statewide HBP coordination programs show that awareness, treatment, and control status are similar among groups using similar definitions of HBP. When compared with national data from the 1974-75 HANES survey, which defined HBP as 160/95, the comparable 1978 to 1980 figures for the demonstration states all show substantially higher percentages of hypertensives aware of their condition, on treatment, and under control.

Cont. From p. 5, Support

reinforcement from group recognition of their accomplishments.

Each session starts with BP and weight checks. An informational slide-tape presentation provides the day's theme. Sessions finish with a group interaction activity enhanced by a relaxation or hand-warming exercise to aid the discussion process. The six topics covered are hypertension, stress, medication, nutrition, lifestyle changes, and decisionmaking.

While funds for program plans and materials came from 317(a)(1) monies through the Kansas Department of Health, a $20 participant's fee covers operating expenses for the 6-week time period. Because the program is self-supporting and allows one facilitator to interact with several patients at a time, "It's Up to Me" is now offered in several Kansas hospitals.

For more information, contact; Alan P. Janssen, MSPH, University of Kansas--Wichita, School of Medicine, 1001 N. Minneapolis, Wichita, KS 67214; (316) 268-8272.

Maryland pharmacists monitor medication refills

Approximately 100 community-based pharmacists in Maryland have integrated into their practices a system for reminding HBP patients to refill their medication prescriptions and for helping them to know more about the disease. Designed by the Pharmacy HBP Control Program of Maryland, the system includes:

- patient medication profiles that the pharmacist monitors for refill dates;
- reminder postcards that are sent to patients 1 week before their prescription(s) run out;
- medication information slips with a HBP health message given to the patient when medication is purchased;
- a patient pamphlet, Your Pharmacist and HBP Control;
- pharmacy posters "Ask Your Pharmacist About the HBP Control Program"; and
- data collection forms which provide the program with documentation.

Pilot testing and documented experience indicates that the program is compatible with current pharmacy practice and causes minimal disruption to the pharmacist's routine.

For more information, contact: Donald O. Fedder, Pharmacy High Blood Pressure Program of Maryland, University of Maryland School of Pharmacy, Baltimore, MD 21201; (301) 528-6989.

Readers tips

This column offers practical advice from our readers on aspects of HBP program planning, operation, and evaluation. All readers are invited to contribute ideas based on their program experience. Send your ideas to: Editor, InfoMemo, High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, MD 20205.

--The Ventura (California) County Health Care Agency uses three coordinated wallet cards to reinforce verbal communications and promote continuity for its HBP patients. A recording card contains space for noting 19 BP measurements, the personal BP goal, and a brief list of important HBP facts. It also contains a telephone number where clients can get further information. Those who have elevated pressures at screening receive a referral card, which contains a brief statement about the elevation along with a space to record it and further remeasurements. The message on the referal card concludes with direction for "next steps" the client should take. Patients get immediate visual feedback from the graphing card, where

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the client or technician can chart information about lowering BP's. Samples of the cards are available to InfoMemo readers.

**Bill Miley, Director, HBP Education Program, Public Health Services, Ventura County Health Care Agency, 3147 Loma Vista Road, Ventura, CA 93009.

--Baltimore elementary school children are learning about the hazards of a high salt diet using a new board game, "Hold the Salt." The object of the game is to accumulate the lowest sodium count. Depending on the roll of the dice, children land on either high or low sodium foods. If they land on high sodium foods, there are various changes they can make, such as changing canned food for fresh or removing the pickle from a hamburger. Children "win" the game by keeping their sodium intake to 1 teaspoon of salt per day.

**Dr. Ruth McKay, 101 E. Melbourne Ave., Silver Spring, MD 20901.

--The Pharmacists' Subcommittee of the Connecticut Health Commissioners Council on High Blood Pressure uses an inexpensive, efficient system to distribute HBP information to pharmacies. Four wholesale drug companies distribute the HBP consumer pamphlets, reorder forms, and professional education materials to pharmacies throughout the state during routine deliveries of drug shipments. More than 90 percent of Connecticut's 700 pharmacies receive information through this system. Because the wholesalers charge no fee, the only distribution cost is delivering materials in bulk quantities to the four wholesaler locations.

**Henry A. Palmer, Assistant Dean for Clinical Affairs, University of Connecticut School of Pharmacy, Storrs, CT 06268.

--The Tompkins County Department of Health in Ithaca, New York, is working with volunteers from Cornell University's health fraternity to provide HBP screening, education, and followup monitoring to the university's 16,000 student and 7,000 employee population. The small department also extends its capabilities by coordinating community HBP control efforts, including providing followup for the local American Heart Association and Red Cross screening programs and offering services through churches, fire departments, and the county department of social services.

**Diane Griffeth, Director, Hypertension Control Program, Tompkins County Department of Health, 1287 Trumansburg Rd., Ithaca, NY 14850.

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1982, No. 4

Worksite demo projects: new insights, positive results

Three worksite demonstration projects sponsored by the National Heart, Lung, and Blood Institute have completed their 3-year programs. The demonstration efforts, involving the Maryland State government, Ford Motor Company sites in Michigan, and Westinghouse plants in three states, tested different techniques and drew various conclusions about the effectiveness and efficiency of approaches to high blood pressure (HBP) control in the workplace. All the programs noticeably increased employee BP control.

Ford Motor Company

The Ford project offered different types of activities at each of its four plant sites. Site 1 was a control group, receiving only the screening, rescreening, and referral services offered periodically to participants at all sites. At site 2, semiannual followup with hypertensives occurred; employees received either standardized followup activities or unstructured, individualized interventions. Employee followup and followup with physicians occurred at Site 3. Site 4 offered onsite treatment and onsite monitoring.

Program results show that the site 4 employees who chose onsite treatment achieved the highest level of control (89 percent had readings below 140/90 mm Hg). While improvement in control status occurred at all four sites, control was better for those at sites 2, 3, and 4 than for those at the control site. In a substudy conducted at site 3, 50 randomly selected patients received sphygmo-

Cont. on p. 2, Demo Projects

Editorial

The workplace: a HBP resource for employees and the community

The results of the worksetting HBP control demonstration projects discussed at left illustrate three fundamental reasons for sponsoring and supporting worksite programs. They improve HBP control among employees, they can help industry contain employee health care costs, and they can reduce premature death and disability among key personnel.

Positive results such as these, however, are not the only reasons the worksite is important. From a community standpoint, the private sector is becoming an increasingly valuable potential source of support. The experience worksites develop in sponsoring programs for employees can be a resource for other state and local HBP control programs or coordinating councils. Companies with HBP programs may also

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be a source of financial support or in-kind contributions, such as educational materials, equipment, or facilities.

In addition, firms with workplace programs can benefit the community by extending services to employee dependents. Because dependent-related expenses represent a major percentage of many employers' health care costs, HBP control for dependents can also make good financial sense.

For employers interested in offering more comprehensive employee health promotion/risk reduction activities, sponsoring a HBP control program can be a sound first step for two reasons. First, its effectiveness in reducing cardiovascular disease risk is well documented. Second, many of the health habits that programs help hypertensives to develop and maintain are also fundamental to reducing cardiovascular risks for the nonhypertensive. Thus, the interventions companies may develop to help HBP patients improve nutrition, get more exercise, stop smoking, or reduce stress can serve as pilot efforts for expanded employee preventive health services.

Those trying to promote worksite programs in the community or employers planning to offer HBP services should remember that the range of program options is wide. An employee HBP program can provide general employee education; education and monitoring for diagnosed hypertensives; detection, referral, and followup services; treatment; or any combination of these components. An employer may use all in-house resources, contract with community agencies for services, or provide some components and cooperate with outside groups for others.

Although the programs described on pp. 3-6 do not present a comprehensive picture of work-setting efforts, they do illustrate important options, participants, and potential in worksite HBP control. Those who want more in-depth information may find the materials listed on p. 7 a good place to start.

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Demo Projects, cont. from p. 2

manometers and instruction in home monitoring; no significant differences in control resulted.

Maryland State Employees

In another demonstration project, State employees at the Preston Street complex in Baltimore received periodic screening, referral, and followup services. Educational sessions on blood pressure, nutrition, and smoking were also available. In addition, the program monitored all those with diastolic pressures above 85 mm Hg at first screen (referred to as "high normals") who were not confirmed as hypertensives after three separate readings on up to four occasions.

The majority of identified hypertensives were treated by their own physicians, but investigators established an onsite clinic to treat the small number who chose not to use community care. Study results showed that community care with followup from the worksite is an effective method of HBP control.

Control improved substantially among employees during the program and investigators found that success in controlling high blood pressure was greater for those with lower elevations at screening. Initially, only 43 percent were under control, defined as diastolic blood pressure (DBP) below 90 mm Hg. After 24 months, 68 percent had achieved control. For those employees with diastolic readings 95-99 mm Hg, 53 percent achieved control and for those with DBP readings greater than 99 mm Hg, 48 percent achieved control. Although control at DBP 90 mm Hg was not achieved as often among those

with higher elevations, significant BP reductions did occur.

For the "high normal" group, the project found that 4.3 percent of those whose initial DBP was between 85 and 95 mm Hg were subsequently diagnosed as hypertensive; but the percentage almost doubled among those with initial elevations greater than 95 mm Hg. Investigators thus concluded that in monitoring individuals without confirmed hypertension, more frequent followup for those with single elevations above 95 mm Hg may be advisable.

This study also revealed important facts about the effects of HBP on the workforce. Records reviewed indicated that hypertension may be related to as many as 40 percent of early retirements among all State employees (not just those at the program site). In addition, the average age of hypertensives in the program was 51, or about 12 years older than the total population screened. Hypertensives were also somewhat more likely than nonhypertensives to have salaries above $20,000. This experienced group, which represents a comparatively significant management investment, reported having four times the number of strokes and more than three times the number of heart attacks than that reported for all screenees.

Westinghouse Electric Corporation

HBP programs at four Westinghouse plants (two in Pennsylvania, one in New York, and one in California) had four major components: publicity/education, screening/referral, followup, and counseling. The programs were staffed locally, with nurses hired on a temporary basis and trained to offer these services. Both screening and one-to-one counseling took place during work hours. Variables from site to site included different approaches to setting up screening, the intensity of outreach in followup, and frequency of counseling sessions.

The program concluded that counseling made a significant difference in BP control. The site with semiannual counseling sessions achieved an 88 percent control rate among continued participants (90 percent of the group). The most cost-effective program design was one that established individual screening appointments, used telephone followup to contact physicians who had not responded to the referral questionnaire, and held semiannual counseling sessions.

The per employee cost of screening averaged $4.61. Typical cost for following up on referrals was $2.26 for each employee contacted, and counseling averaged $4.68 per encounter.

All three projects have completed final reports detailing their activities and outcome. For further information on the demonstration projects, contact: Judith La Rosa, 4A18, Bldg. 31, National Heart, Lung, and Blood Institute, Bethesda, MD 20205.

BC & BS brings HBP services to Federal employees

Blue Cross and Blue Shield (BC/BS) plans in Richmond, Virginia, Philadelphia, Pennsylvania, Maryland, and Indiana, in conjunction with the Federal Office of Personnel Management, are working with Federal agencies and community health groups to offer HBP control services to Federal employees. The pilot program will be evaluated at the end of 3 years to assess its impact on hospital costs and utilization rates; the program may then be extended to other Federal agencies.

The BC/BS plans are working cooperatively with agency occupational health personnel from the Division of Federal Employee Occupational Health (Public Health Service) and others to follow up on physician referrals and to monitor the control status of identified hypertensives. Approximately 35 Federal agencies are participating in the effort.

Community volunteers, including health professional students and voluntary agency members, are trained by Blue Cross/Blue Shield to measure BP's at semiannual screenings. BC/BS provides educational materials for employees and has developed an information system to record and evaluate relevant data for the employees it insures. Because the Federal agencies and community groups are providing the services themselves, however, the employee programs are designed to be self-sustaining even when pilot program funding ends.

The BC&BS Federal Employee Program became interested in offering hypertension services after plans in Connecticut, Delaware, and Michigan reported positive results from similar programs they sponsor for local industries. The plans' experience also suggested that their approach had been a cost effective way of providing worksite services. The cost issue is an important one for Blue Cross, whose 1980 Federal employee benefit payments nationwide for HBP-related cardiovascular disease exceeded $177 million; another $11.6 million was paid for hypertensive heart disease.

For further information, contact: Peter LeBrun, Project Director, Blue Cross & Blue Shield Association, 676 N. St. Claire St., Chicago, IL 60611.

State, nurses group cooperate to expand industry activities

In North Carolina, the State Division of Health Services and the State organization of the American Association of Occupational Health Nurses (AAOHN) are sponsoring a program to interest and train occupational health nurses in workplace HBP control. By working with the well-organized nurses association, the State Health Department has so far been the catalyst for more than 100 new efforts to establish HBP control programs in industry. Its goal is to reach 400 companies statewide that employ members of the nurses association full time.

Although the Division of Health Services provided the $10,000 funding for the project from its Federal preventive health services block grant, a nurses committee and the State's occupational health nurse consultant developed program components. These include:

- A promotional workshop, last year held in conjunction with the State safety meeting, which many nurses traditionally attend; and
- A 1-day training session that provides basic information on how to interest management in worksite HBP control, measurement/treatment protocols, and effective HBP patient counseling.

The program also provides sphygmomanometers (and calibration training), standardized forms to use in followup activities, and wallet cards for patients to all nurses who complete the training session. All worksites agree to document results, which the nurses group aggregate and share with the division of Health Services. In turn, the State evaluates the data and provides each BP project with statistics on control status and program effectiveness.

North Carolina plans to continue working with the nurses group to develop workplace programs for other chronic diseases, particularly diabetes. Such cooperative arrangements can also be made on a smaller scale. If a statewide effort weren't feasible or desirable, for example, a state or local health department could work with one or more of the AAOHN regional subgroups (constituents) in that state.

For further information, contact: Kathy Brownfield, P.O. Box 2091, Raleigh, NC 27602. (919) 733-3680.

Urban university: HBP control for students and employees

For several years, the HBP control program at the University of Wisconsin/ Milwaukee (UWM) has helped UWM students, faculty, and employees learn about and control their HBP. Through publicity, education, detection/referral, and followup activities at sites and times convenient for students and staff, UWM has screened thousands of individuals. Forty-nine percent of detected hypertensives have reached and maintained goal BP's. Substantial reductions in smoking and alcohol consumption, as well as weight loss for many indiviuals, have also occurred. The university, a large employer that is also similar to a workplace for students, has had an opportunity to reach a large number of undetected/untreated hypertensives, especially young males.

UWM medical college and student health department staff developed the program in cooperation with the Milwaukee HBP Program and the local health department, medical society, and affiliate of the American Heart Association (AHA). Program design includes:

- prescreening publicity in local and campus newspapers and in high-traffic display areas;
- BP screenings at permanent and temporary locations;
- referrals to private physicians; BP monitoring and medication renewals for well-controlled hypertensives at the university, in cooperation with the private physicians;
- campus HBP treatment services for students not selecting private care;
- outreach activities and patient tracking systems to aid in followup;
- HBP and cardiovascular risk factor education and evaluation;
- lifestyle modification programs; and
- data collection and analysis for epidemiologic and medical research.

The program obtains materials and support from many sources. For example, screening personnel, originally from Milwaukee AHA, are recruited through campus groups; student health department staff train these student volunteers. In addition, drug company literature supplements individual counseling sessions conducted by the student health nurses.

Residents of the university community, although not program participants, also benefit from the UWM program. They can attend campus screenings and be referred to their physician, if warranted. They also receive HBP education through the community newspaper articles placed by the student health department health educator as well as through the poster displays.

For more information, contact: Dr. William K. Hoffman, Director, Department of Student Health, University of Wisconsin/Milwaukee, P.O. Box 413, Milwaukee, WI 53201 (414) 963-4716.

Employees and community benefit from hospital worksite programs

Provident Hospital, Baltimore, Maryland, and St. Joseph Hospital, Bangor, Maine, have employee programs for detecting and referring hypertensives and to provide patient education and counseling. In addition, St. Joseph Ambulatory Health Services staff provide these services, among other health education activities, for Bangor worksites. Provident plans to provide hypertension control services to the community as a future component of its effort.

The Provident program design follows protocols for detection and referral recommended by the American Heart Association (AHA), Maryland Affiliate Worksite Program, which is conducted in cooperation with the Maryland High Blood Pressure Coordinating Council. After staff orientation through display of AHA posters and letters to each department, two nurse practitioners screen voluntary participants and record BP readings on standardized forms. The forms collect data for Maryland Health Department statistics.

Detected hypertensives are referred to a source of health care or their private physician, who receives a letter and form on which to indicate the followup activities desired--monitoring, HBP education, and/or dietary counseling. All employees screened are followed up in the next month.

The nurse practitioners conducting this program have also developed a three-stage hypertension treatment program consisting of (1) an outpatient clinic; (2) an inpatient hypertension treatment team of physicians, dietitians, a social worker, nephrologist, and cardiologist; and (3) community services. Stage 1 has been in operation for 1 year, and stage 2 for 3 years. Plans are being developed for stage 3, whereby private physicians can refer hypertensives to the clinic and the treatment team.

The St. Joseph program encompasses a number of health education/disease prevention activities available to hospital employees and, on a fee-for-service basis, to Bangor industries. Included among the Hospital's Wellness Center offerings are a course in understanding hypertension and how to maintain optimal health through lifestyle changes; a health assessment and screening service, including BP measurement and followup and referral activities; and nutritionist-conducted programs on weight reduction and low sodium diets. The hospital promotes these services through letters to management and a quarterly newsletter, which also highlights industry health promotion activities and discusses such health topics as stress management, hearing conservation, health screening, and the need for physical examinations.

For more information on Provident's program, contact: Rosa Cain, Provident Hospital, 2600 Liberty Heights, Baltimore, MD 21215. (301) 225-2130.

For more information on St. Joseph's program, contact: Jeanne Smaha, R.N., St. Joseph Hospital, Bangor, ME 04401. (207) 947-8311.

Worksetting HBP control materials

Available free from:

High Blood Pressure Information Center 120/80 National Institutes of Health, Bethesda, MD 20205.

Cardiovascular Primer for the Workplace, an introduction for people in business and industry outlining knowns and unknowns about cardiovascular disease risk reduction, facts to consider for a given employee population, sources of information, and descriptions of existing programs. 88 pages.

Cost of Worksite Hypertension Treatment, by Hirsh S. Ruchlin and Michael H. Alderman, for those interested in worksite treatment. 46 pages.

High Blood Pressure Control in the Worksetting: A Selected Bibliography, 5 pages.

High Blood Pressure Control in the Worksetting: Proceedings of the National Conference, October 1976, Washington, D.C., includes; issues, models, and resources. 102 pages.

High Blood Pressure in the Workplace Fact Sheet, summary of prevalence, risks, deaths, absenteeism, and lost earnings among workers due to HBP. 1 page.

Re: High Blood Pressure Control in the Worksetting, Special Programs Issue, describes seven established programs. 12 pages.

Available from:

Health Education Services, P.O. Box 7126, Albany, NY 12224.

A Handbook for Worksite Blood Pressure Programs, general information manual on conducting HBP control programs at worksites. New York State Department of Health, 1980. 36 pages. $1.25 plus $.59 postage and shipping for 1 copy; add $.22 per copy up to 10. For more than 10 copies, costs are: $1.25 per copy plus $1.91, postage and shipping, add $.13 per number of copies over 10. Payment must accompany order.

Put the Effects of High Blood Pressure Out of Business: Employer Information Kit, New York State Department of Health. Includes posters, pamphlets, announcements for public address systems, and news releases. Free sample copy only.

Available from:

Institute of Labor & Industrial Relations, c/o Worker Health Program, 401 Fourth Street, Ann Arbor, MI 48103

Blood Pressure Control at the Worksite; Manual of Procedures for Blood Pressure Control Programs in Industrial Settings, by John C. Erfurt and Andrea Foote, includes step-by-step procedures and protocols, and sample forms, 1979. 83 pages. $5 per copy for order of 1 to 9 copies, $4 per copy for orders of 10 or more.

Reference reading:

La Rosa, J. and Ziska, D. "Lowering Employee Blood Pressure--and Costs." Nation's Business, December 1981; pp. 72-74.

Occupational Health Nursing, November 1981, entire issue devoted to high blood pressure. 66 pp.

Logan, A., et al., "Cost-Effectiveness of a Worksite Hypertension Treatment Program." Hypertension, Vol. 3, No. 2, March-April 1981, pp. 211-218.

Readers' tips

This column offers practical advice from our readers on aspects of HBP program planning, operation, and evaluation. All readers are invited to contribute ideas based on their program experience. Send your ideas to: Editor, InfoMemo, High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, MD 20205.

--Nurses at the Worthington Group McGraw-Edison Company regularly send birthday cards with HBP messages to employees. The cards invite them to visit the Employee Health Office to receive a "gift": an annual BP recheck.
**Dorothy Haselbauer, R.N., 1036 Rath Bldg., 95 Franklin St., Buffalo, NY 14202.

--Working with an enthusiastic person at a target company makes it easier for the Camden County Health Department to stimulate and implement worksite programs. Health department staff locate potential contacts by talking with other community health agencies (e.g., Red Cross, United Way) and/or company officers. The department involves the contact person in scheduling, coordinating, and running activities, which helps promote company "ownership" of the project and builds rapport. Often the company contact takes on a proactive role, asking the health department for services or providing informal followup for hypertensive employees.
**Camy Trinidad, Camden County Hypertension Project, 312 Cooper St., Camden, NJ 08101. (606) 757-6858.

--The Danbury Hospital HBP program provides the Danbury, Connecticut community with HBP education through cooperative arrangements with the hospital's public relations department and a local college. Radio spots and an interview program are produced at the hospital for local stations. A video tape that is available to TV stations was produced by Western Connecticut State College with the help of the hospital's HBP program director.
**Dr. Howard Garfinkel, Chief of Nephrology and Hypertension, Danbury Hospital, Danbury, CT 06810. (203) 797-7104.

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to: Participants, National High Blood Pressure Education Program

from: Graham W. Ward, Program Coordinator

1982, No. 6

Editorial

An approach to community problem solving

About a year has passed since block grants and budget cuts became facts of life for the HBP control community. The article at right presents some of the initial ways state and community programs are responding to the new budgetary and program realities. The "solutions" these programs have developed for their problems are good ones that other communities may be able to adapt.

Because the block grant system is new and mechanisms differ from state to state, however, communities may find that as yet there are no precedents to guide decisions they need to make now. The following five-step approach to problem solving is a generic method that can help communities pinpoint needs and develop workable ways to meet them.

Step 1. Define the problem. (Isolate it; put it down on paper so everyone involved in finding a solution starts with a common understanding. This is the initial evaluation.)

Step 2. Define the operational constraints. (Outline the program's limitations. Separate the things which can be changed from those which cannot.)

Step 3. Look for alternative solutions. (Rarely is there only one answer, one approach, one response; look for all possibilities.)

Step 4. Pick one of the alternatives and implement it. (The final choice, usually, is one that fits best with existing constraints, such as resources, local politics, and competing priorities.)

Step 5. Reevaluate to assess the effect of your action. (When you do anything at all, the situation changes. The problem may be solved, or it may be a

continued on p. 7

Coping: creative approaches for austere times

In fiscal year (FY) 1982, hypertension control joined 11 other health-related programs receiving Federal funding from the preventive health services block grant. The block grant approach allows the states to allocate and use Federal funds with fewer restrictions and less accountability. But total funding for the preventive block was reduced for fiscal year 1982 by 25 percent, with additional decreases projected for the next 3 years.

HBP control was given a "categorical" status in the preventive block, which mandated each state to fund hypertension efforts at no less than 75 percent of 1981 levels. A number of states funded their HBP programs in 1982 at levels above the 75 percent minimum by supplementing Federal monies with state funds, by allocating HBP a greater share of the preventive block, or by allotting a discretionary percentage of other health-related blocks to hypertension control. These include Utah, Ohio, Illinois,

National High Blood Pressure Education Program National Heart, Lung, and Blood Institute
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service National Institutes of Health

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Washington, New Mexico, Georgia, South Carolina, Kentucky, Arizona, and Idaho.

State and community programs have responded to the new system by learning how to work within it and learning how to make it work for them. The following is a compilation of approaches programs have used to compete strongly for the reduced Federal monies, to find new sources of funding, and to put the resources they have to most efficient use.

Increasing visibility

State and community programs have identified lack of recognition as a major barrier to their ability to maintain or increase their share of Federal monies and other available resources. To increase their visibility and credibility to the public, the legislature, and others who influence decisions, programs are:

- **Using HBP Month to publicize hypertension concerns and their role**

The Greater Cleveland HBP Coalition, a 30-agency city-wide coordinating council, took advantage of May 1982 to publicize its 2-year-old program and its month activities. For example, the coalition developed a month calendar with daily listings for morning and afternoon HBP activities at sites around the city. The calendar was widely covered in newspapers, radio, and television broadcasts. Coalition director James Deyling notes that by listing themselves as a source of further information on the calendar, the coalition increased its contacts with interested citizens and increased its public identification with HBP. This was reinforced by TV appearances (on talk shows and as part of a presentation of NHLBI's locally adaptable "Silent Disease" program) by representatives of member agencies, who publicized May events and the coalition's role.

For further information, contact: James Deyling, Greater Cleveland HBP Coalition, Inc., 1800 E. 105th St., Cleveland, OH 44106; (216) 421-4473.

- **Forming a local coordinating council.**

The Arkansas Affiliate of the American Heart Association is coordinating the newly formed Pulaski County HBP Task Force, a community group that includes physicians, pharmacists, blacks, senior citizens, nurses, teachers, and National Guard members. The Heart Association is cooperating with the Arkansas Health Department on this project, which has the added benefit of strengthening their interaction. Association director Carl Smith believes that the Heart Association's new role capitalizes on its well-established relationships with local HBP actors and enhances its visibility in a leadership role. By coordinating county activities, the group plans to redirect the focus from detection to followup and maintenance, and plans to broaden the base of volunteer support.

For further information, contact: Carl Smith, Arkansas Affiliate, AHA, 909 W. 2nd St., Little Rock, AR 72201; (501) 375-9148.

- **Forming a citizens support group.**

Interested citizens in a number of states have joined together to help keep their state legislators and other influential leaders informed about needs and accomplishments in HBP control. In Michigan, a core of involved residents contacted 50 well-known people in business, politics, entertainment, and other sectors to provide visible leadership for the effort.

The group initially sponsored a public forum on HBP featuring prominent speakers. Presentations were summarized and distributed to legislators and health leaders. Other activities have included a dinner for legislators with presentations on HBP needs, development and distribution of a state HBP fact sheet, and a newsletter to keep the group itself informed about HBP efforts. One major phone call/letter-writing campaign

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to the legislature helped ensure that state HBP monies were spent as allocated.

Group member Abby Caine-Rosenthal notes that mobilizing private support for HBP control has been easier than she had expected. Legislators have been generally sympathetic to the HBP messages, because many of them, their families, and constituents have hypertension. They also appreciated personal "thank you" visits group representatives made to legislators after a favorable vote.

Ms. Rosenthal believes the group's success comes from understanding the political structure and taking advantage of the close connections many of the members have with state leaders. The group also coordinates its efforts with those of other voluntary and professional organizations that support HBP control.

For further information on the Michigan group, contact: Abby Caine-Rosenthal, United Community Services, 51 W. Warren, Detroit, MI 48201; (313) 545-3261.

For information on similar programs in New York, Georgia, Washington, Illinois, Pennsylvania, New Jersey, Maine, Indiana, and California, contact: Gerald Wilson, Citizens for the Treatment of HBP, 1140 Connecticut Avenue, Suite 604, Washington, DC 20036; (202) 296-7747.

- **Ensuring strong internal support within the organization.**

In Washington state, decisions on allocations of preventive health block grant funds are formally made by the legislature. However, the Department of Social and Health Services makes detailed recommendations which legislators to date have closely followed. Thus support for HBP control within the Division of Health is an important factor in the hypertension program's ability to maintain or increase program funding.

State coordinator Fred Abrahamson believes that maintaining visibility is the key to maintaining internal support. Washington's HBP program is thus focusing its efforts on a highly visible program -- a network of 160 screening, referral, and followup centers. This program has a computerized data collection system, and Abrahamson communicates resulting information on prevalence, referrals, and control status to his superior, the chief of the health division. The chief widens internal awareness on program successes and needs by including this information in the overall department's management bulletin. One outcome was the department secretary' shaving directed the public relations office to write a news release on the hypertension program's activities and accomplishments, which was widely carried by state media. The department allocated HBP a greater share of funding than the preventive block grant formula mandated in fiscal year 1982, and recommendations for FY 1983 maintain the programs at FY 1982 level, despite declining resources and proposed cuts for department programs overall.

For further information, contact: Fred Abrahamson, Department of Social and Health Services, P.O. Box 1788, Mail Stop LB12A, Olympia, WA 98504; (206) 753-3494.

- **Using CDC survey to make a data based case for HBP needs.**

Not all states can support a sophisticated, ongoing data collection system such as Washington state's. But a telephone survey instrument available from the Centers for Disease Control includes questions on HBP that can yield hard facts to help programs convincingly outline HBP needs. The hypertension section of the questionnaire, which also deals with other risk reduction topics such as smoking, exercise, nutrition, and stress, elicits information about prevalence, treatment, control status, and adherence. CDC's Gary Hogelin estimates that about 20-25 states will use the risk reduction survey by the end of 1982. CDC gives states the instrument, technical assistance in using

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it, and on-site assistance in training and supervising interviewers; the Atlanta agency will also provide data processing or give states the software to do it themselves. The states must underwrite the interviewers' salaries and printing of survey results. Hogelin notes that with minor modifications, the survey could be used by local groups as well.

For further information, contact the health education/risk reduction coordinator in your state health department or Gary Hogelin, (404) 329-2564.

Finding new sources of funding

To supplement funding available to HBP through the Federal block grant and state allocations, programs have obtained support in a number of other ways:

- **Cost-recovery.**

The Mississippi Health Department sponsors HBP treatment clinics that provide ongoing care and medication. Medication is offered without charge to those with low income levels. As a means of cost recovery, the department files insurance claims for reimbursible services (e.g., medical evaluation, EKG, X-rays) for those who have third-party payors. According to state coordinator Virginia Pace, last year the reimbursements were the major pool of funds supporting the costs of purchasing the HBP medications for free distribution.

For further information, contact: Virginia Pace, Mississippi State Board of Health, P.O. Box 1700, Jackson, MS 39205; (601) 961-4088.

- **Fee-for-service.**

The Clackamas County, Oregon, Department of Human Resources served as a pilot for the Food-Wise Graphics Hypertension Control Program. This program provides graphic grocery store shelf markers that alert shoppers to low-sodium foods. All 17 major grocers in the area agreed to participate. The effort prompted extensive press coverage for the health department and broadened its base of cooperation with one of the county's largest industries as well as with medical and community groups.

Two additional Oregon counties are planning similar efforts. These projects, however, will charge each grocery $195 per set of shelf markers. Based on grocer response in the pilot, says program designer Larry Raff, the counties will use several rationales to enlist grocer participants.

-- nutrition programs are a public service which put retailers in a better competitive position;
-- press promotion possibilities for the program are a valuable advertising asset;
-- retailer enrollments will oblige competitors to follow suit;
-- some of the foods promoted by shelf markers will carry a higher profit margin than slower moving competing products;
-- retailers can expect to attract new customers who are concerned about health or on sodium-restricted diets. Raff also suggests stressing the high prevalence of HBP in your area, and notes that attracting only two new families as grocery store customers will pay for the program.

The charges for the shelf markers, adds Raff, will more than cover the costs of the materials.

For further information, contact: Larry Raff, P.O. Box 15284, Portland, OR 97215; (503) 223-1030.

- **Foundation support.**

The Greater Cleveland Coalition successfully supplements its funding with a 3-year grant from the Cleveland Foundation. The grant is for general support and provides about one-fifth of the coalition's budget;

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continued work on the coalition's emergency room patient tracking system is the major requirement.

Coalition director James Deyling believes that focusing the grant application on serving a low-income, hard-to-reach population, coordination with a variety of city organizations and agencies, and the cost effectiveness of coalition efforts was important to their success. He notes that a grant like this from a prestigious foundation increases the local and national credibility of the coalition and should make it easier to approach other funding sources.

For further information, contact: James Deyling, Greater Cleveland HBP Coalition, Inc., 1800 E. 105th Street, Cleveland, OH 44106; (216) 421-4473.

- **Other block grant funds.**

In Utah, the state hypertension program received funding from the preventive health services HBP monies and applied successfully as well for additional funding in another preventive health block category, health education/risk reduction. Coordinator Joan Ware says that this allowed HBP to retain its 1981 funding level. As a programmatic issue, it also allowed her to expand HBP patient education programs to include important co-risk factors such as smoking and poor nutrition and to broaden the programs' family focus.

For further information, contact: Joan Ware, Utah Department of Health, P.O. Box 2500, Salt Lake City, UT 84110; (801) 533-6141.

- **In-kind support.**

The Southeastern Pennsylvania HBP Control Program extends its budget with contributed facilities management support, and student intern staff time. The nonprofit, self-sustaining program includes a central coordinating council and five local coordinating councils in the large five-county metropolitan Philadelphia area. The Philadelphia City Health Department provides free office space for the central council and operational support such as use of equipment. Interns from a local secretarial school, as part of a practicum, perform clerical and recordkeeping tasks, and public health school interns help administer programs for field work credit.

For further information, contact: Cathy Stauffer, 500 S. Broad St., Rm. 166, Philadelphia, PA 19146; (215) 546-1276.

- **Categorical state funding.**

Legislation was passed in New York State establishing and funding a heart and hypertension institute within the state health department. The institute supports four major areas of program activity: epidemiological and health systems research, professional and public education, centers for treatment of hypertension, and regulation of health facilities regarding blood pressure detection and control.

The institute has been placed organizationally in the bureau of chronic disease prevention, which includes the diabetes, health-risk reduction, nutrition, and cancer control programs. This also promotes cost efficiency through sharing of resources, particularly the core capacity of epidemiological and data management personnel.

For further information, contact: David Momrow, Director, Hypertension Program, Empire State Plaza, Room 672, Albany, NY 12237; (518) 474-0932.

Using resources efficiently

HBP programs have found that one way to cope with fewer resources is to make the most of those you have. Some ideas include:

- **Making the most of volunteers.**

The Wisconsin Division of Health stresses volunteers as an underused program resource that can save money and build community support. For many programs, says state HBP coordinator Tom Schuler,

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the volunteer conjures an image of retired nurses measuring blood pressures. In Wisconsin many different people with a wide variety of skills and backgrounds are HBP program volunteers. Activities in which they participate include 1) planning and organization, (administration, collecting data, assessing health resources, community group liaison); 2) resource development (recruiting other volunteers, soliciting donated services or equipment, fundraising); 3) publicity and education (community outreach, designing educational or media materials, speaking, contacting public officials and community leaders); 4) providing direct HBP services (secretarial or recordkeeping work, counseling patients, providing childcare, or transportation, maintaining facilities and equipment); and 5) followup (making referrals; telephone, in-person, or mail contacts, developing/maintaining medical referral list). A future issue of the InfoMemo will report on some of Wisconsin's approaches to recruiting and training volunteers.

For further information, contact: Tom Schuler, Wisconsin Division of Health, P.O. Box 309, Madison, WI 53701; (608) 267-7250.

- **Sharing a data system.**

When Washington state developed its computerized data collection system for HBP control, the Idaho state hypertension program converted its tracking efforts to the Washington model, whose design was made available at no charge. Both states now pay their own portions of charges at the common data processing service center. In addition, notes Washington's Fred Abrahamson, both save money by splitting the costs of modifications to the system. The higher volume produced by the combination lowers processing rates. As a program planning tool, using the same system allows direct comparison of results and needs between the two states.

For further information, contact: Fred Abrahamson, Department of Social and Health Services, P.O. Box 1788, Mail Stop LB12A, Olympia, WA 98504; (206) 753-3494.

- **Eliminating subcontracts.**

In the past year the New Mexico state HBP program hired six district level hypertension nurses to perform coordination and education tasks the state had previously subcontacted to a variety of local groups. State coordinator Catherine Salveson has found that she has more control over results at less expense.

Administratively, it is no longer necessary to take the time to monitor the efforts of the various subcontractors. Programmatically, the state has been able to take a more consistent, overall direction, for example restructuring all its HBP clinics to focus on control rather than detection. Financially, 100 percent of allotted funds are now used for this task, rather than in part contributing to the general support of a subcontracting group.

For further information, contact: Catherine Salveson, Bureau of Chronic Disease Control, P.O. Box 968, Santa Fe, NM; 87503; (505) 827-3201.

Other Ways to Cope

The ideas presented above are not a representative list of solutions and do not address all of the problems HBP programs are identifying. Readers are encouraged to contribute their own ways of coping with problems others may share. Send ideas to: Editor, InfoMemo, 120/80 National Institutes of Health, Bethesda, MD 20205.

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Editorial Cont. from p. 1

different one, but the situation is definitely changed.)

This approach, which is adapted from the NHBPEP's newly available Community Guide to High Blood Pressure Control*, is complemented by the Guide's list of the 10 most important factors for a successful BP program. In setting program priorities, these are critical elements to keep in mind.

I. Offer services for every step in the high blood pressure control process including followup care, or coordinate services with other community efforts so patients have access to care at every step in the process.

II. Integrate the following activities as components of the program: public, patient, and professional education, and patient tracking.

III. Make the services and activities readily available to the communities you serve.

IV. Ensure that residents of the community know about the services.

V. Have a commitment to long-term involvement in high blood pressure control, rather than emphasizing short-term efforts, such as one-time educational campaigns and irregular screenings.

VI. Have a defined organizational structure.

VII. Use established procedures and protocols.

VIII. Cooperate and coordinate with other high blood pressure control efforts, including organizations interested in high blood pressure control, health care institutions, providers, and professionals in other settings, such as pharmacists.

IX. Develop every possible local source of support for program efforts.

X. Have an interdisciplinary leadership that understands the high blood pressure control process and is dedicated to its success.

Following the problem-solving approach and considering these important factors will not automatically reveal appropriate solutions or the best techniques. It will, however, contribute to a logical examination and ranking of program needs and activities. This may be the most important element, because no problem can be solved until it is properly defined and understood.

GWW

* To receive a copy of the Community Guide to High Blood Pressure Control, write: HBPIC, 120/80 National Institutes of Health, Bethesda, MD 20205.

Readers' tips

--The St. Mary Medical Center in Gary, Indiana, has formed an interdisciplinary health education advisory committee to coordinate patient education efforts. This committee has streamlined and reduced duplication in high blood pressure education by offering one program with standard handouts. Previously the stroke team, the cardiac rehabilitation program, and the department of education each had separate high blood pressure programs.

**Catherine Warrick, Patient Education Coordinator, St. Mary Medical Center, 540 Tyler St., Gary, IN 46402; (219) 882-9411.

--The Sterling Area Health Project in Arenac County, Michigan, uses a high blood pressure quiz to integrate patient education into blood pressure screening encounters. Several varieties of the quiz have been developed for use with normotensives and those with elevations. Questions deal with how often blood pressures should be checked, risk factors for heart disease, diet and high blood pressure, and long-term control. Screeners check screenees' answers and correct misconceptions or reinforce awareness on the spot.

**Roger Rushlow, Sterling Area Health Project, 725 E. State St., Sterling, MI 48659; (517) 654-2491.

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Percent of hypertensives in specified awareness, treatment and control status categories. (1971-1972 and 1974-1975)

A. Threshold: 160/95 (or taking medication for HBP)

STATUS	71-72	74-75	Percent Change
Unaware	49.1	32.4	(-) 34.0
Aware, no RX	14.4	23.9	66.0
Aware, Inadequate RX	20.0	19.5	(-) 02.5
Aware, Controlled	16.5	24.2	46.7

B. Threshold: 140/90 (or taking medication for HBP)

STATUS	71-72	74-75	Percent Change
Unaware	65.5	48.2	(-) 26.4
Aware, no RX	14.2	24.6	73.2
Aware, Inadequate RX	15.9	19.3	21.4
Aware, Controlled	4.4	7.9	79.5

These charts show that progress has occurred in increasing the number of hypertensives who know about their condition and are controlling it. However, the number of people aware and under control is very small for each threshold and time period, and the number of those unaware of their condition is still substantial.

The differences in status using the 160/95 and the 140/90 levels are also striking. Progress has occurred at both levels. However, in dropping the diastolic goal to 90 (as the Hypertension Detection and Follow-up Program results and the 1980 Report of the Joint National Committee recommend), both awareness and control status markedly decline.

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